



Health Coverage Application Form

You should ensure that You complete Your application carefully, accurately, and fairly. If You are unsure about any matter, you should contact Us.

Requested start date of Coverage cover:

MMMM-dd-yyyy

Cover cannot start until You have accepted all Our terms and conditions following Our receipt of this application form and We have received the correct premium.

Country of Coverage

-Select-



Country

3 Health Plan *

-Select-



Coverage Area

Worldwide excluding the USA

Worldwide including the USA

Optional

Dr. Visit

Medicine

Dental

Vision

Hearing

Rescue

1. Member Details (Please note that the applicant will be the Primary Member)

First Name

Last Name

Nationality:

-Select-



Country

Height (cm/ft):

Weight (kg/lbs):

Occupation:

Are You or any intended member of this policy, or any family member or close associate a politically exposed person?

Yes

No

Address

Street Address

Address Line 2

City

State/Region/Province

-Select-



Postal / Zip Code

Country

Email

Landline full number

Cell Phone

Marital status

- Single
- Married
- Widow
- Single Parent

Genders

- Male
- Female

Date of Birth

MMMM-dd-yyyy

Any Preexisting Conditions?



Dependent

Fill in the form for each dependent including your children if any

Dependent 1

First Name

Last Name

Gender

- Male
- Female

Relationship

Date of Birth

MMMM-dd-yyyy

Weight (kg/lbs):

Height (cm/ft):

Dependent 2

First Name

Last Name

Gender

Male

Female

Relationship

Date of Birth

MMMM-dd-yyyy

Height (cm/ft):

Weight (kg/lbs):

Any Preexisting Conditions?

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Dependent 3

First Name

Last Name

Gender

Male

Female

Relationship

Date of Birth

MMMM-dd-yyyy

Weight (kg/lbs):

Height (cm/ft):

Any Preexisting Conditions?

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Dependent 4

First Name

Last Name

Gender

Male

Female

Relationship

Date of Birth

MMMM-dd-yyyy

Weight (kg/lbs):

Weight (kg/lbs):

Any Preexisting Conditions?



Dependent 5

First Name

Last Name

Gender

Male

Female

Relationship

Date of Birth

MMMM-dd-yyyy

Weight (kg/lbs):

Height (cm/ft):

Any Preexisting Conditions?



Health declaration

If You have more than five Dependents, please use a separate sheet of paper and attach it to this application. You do not need to disclose matters related to common colds, Vaccinations or high fever

Have You or any of your dependent in the last five years ever undergone any Surgical Procedure, been a patient or been treated in a hospital, clinic, sanatorium, nursing home or other medical institution

	Yes	No
Have You in the last five years ever undergone any Surgical Procedure, been a patient or been treated in a hospital, clinic, sanatorium, nursing home or other medical institution	<input type="checkbox"/>	<input type="checkbox"/>
Are You currently taking any kind of medication (other than oral contraceptives), or is any Treatment or tests currently being performed or planned, or any day or In-Patient hospitalization scheduled	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, bronchitis, tuberculosis, pneumonia, or any other respiratory conditions	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders, anemia, hemophilia, thalassemia, or other abnormal blood tests? Have You ever been tested positive for HIV, Hepatitis B or C?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, cyst, polyp, or any abnormal growth whether cancerous or benign?	<input type="checkbox"/>	<input type="checkbox"/>
Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, thyroid disorders or weight management problems?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, multiple sclerosis or other neurological conditions?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	<input type="checkbox"/>	<input type="checkbox"/>
Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	<input type="checkbox"/>	<input type="checkbox"/>
Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or Medical Condition not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>
Females only Have You ever suffered from any breast or gynecological disorders?	<input type="checkbox"/>	<input type="checkbox"/>

Have You ever received Treatment, tests or investigations for, been diagnosed with, or been hospitalized or had signs or symptoms of for:

Additional information

Certificate Holder

Dependent 1

Dependent 2

Depenc

Members

Diagnosis (If none made please describe the exact nature of symptoms suffered)

Date of consultation

Treatment/ Medication received

Date of last treatment/ symptoms

Any underlying cause

Specific location on body including left or right

Outcome (e.g. on-going complete recovery, likely to recur) or for smears, frequency (annually, 6-monthly)



If You answered 'Yes' to any of questions please provide details in the box below. Please provide as much detail as possible, including the date and nature of diagnosis, frequency, and severity of symptoms.

Medicine you or your dependent are taking now

Doctor's contact details

First Name

Last Name

Please give details of Your current usual doctor or the one who is most familiar with Your medical history. Medical Practitioner's details

Phone

Email

Date of last attendance and reason:

Terms and Conditions *

You/I hereby apply for cover on behalf of all the persons named in this application form for a Globalwide Plan as specified above.

I have received and read the Benefit Schedule, Terms and Conditions, Definitions, Benefits, and exclusions of this Plan. I understand that the Application Form, Certificate of Coverage, Benefit Schedule, and the Members' Handbook incorporating the Plan terms and conditions make up the contract between

We all form part of the Plan Agreement. I am aware that cover shall be provided by the Agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my handwriting. I understand it is unlawful for me or my Dependents to GLOBALWIDE provide false, incomplete or misleading facts or information to Globalwide to defraud or attempt to defraud Globalwide. Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of Benefits and legal damages.

- I understand that I must notify Globalwide of any changes in the facts contained in this application forms as a change

- I understand that Globalwide cannot be liable and therefore will not pay claims if my Plan is lapsed should Globalwide be unable to collect my premium for whatever reason and I do not provide Globalwide with an alternate method of payment within seven days of Globalwide requests for alternative methods of payment.
- I agree that where medical Treatment is received within the provider network by me or any of my Dependents and, except where previously agreed by Globalwide, it is determined that the Treatment or Medical Condition is not refundable within the terms and conditions of the Plan, I agree that I am liable to GLOBALWIDE for all claims settled for such medical Treatment in connection with any non-covered claim.
 - I understand and confirm that where I have not repaid funds disbursed in good faith by Globalwide in respect of non-covered medical Treatment, valid claims may be offset against outstanding funds due to Globalwide and/or my Plan may be suspended until the outstanding amounts have been settled in full.
 - I ack GLOBALWIDE ledge that if it is determined by Globalwide that a claim was fraudulent my Plan may be voided with immediate effect.
 - I understand that if I am able to claim any costs from another insurance policy for the cost of any treatment or benefits received, Globalwide will only be liable for a proportional share of the total costs.
 - I have read the important notes.
 - I agree to the declaration above and understand that cover is provided in accordance with the terms and conditions of the Globalwide Plan.
- I accept the Terms and Conditions.

Signature (Coverage Holder/main applicant): *

[Clear](#)

Date

MMMM-dd-yyyy

Upload local Id or Passport for all

Choose File



Review

Save

Submit